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ABSTRACT

The Brief Intervention Program (BIP) is a mental health day program in Melbourne (Australia) for adolescents with severe mental health problems who are at risk for suicide. The 10-week program serves closed groups of 6-8 adolescents aged 13-18 years and has 3 phases: engagement and orientation (week 1), treatment (weeks 2-9), and integration (week 10). Followup support is offered as appropriate for the client's needs. Wilderness-adventure therapy is provided 1 day per week and during two 4-5 day expeditions, and is integrated into other components of the program such as work experience, drama, music, sex education, and group and individual therapies. Wilderness adventure therapy provides a challenging and novel situation that forces clients to relate to others in an adaptive way, allowing for a natural "reconstruction" of developmental gaps as clients correct fundamental assumptions and misconceptions about themselves and others. Based on client need, different and complimentary therapeutic approaches may be employed within the adventure experience, including cognitive-behavioral therapy, psychodynamic interventions, systemic interventions, and occupational therapy. Evaluation information shows significant reductions in general psychopathology and improvements in self-esteem, educational outcomes, social adjustment, school adjustment, and family issues. Five tables depict developmental tasks of adolescence, etiology of adolescent mental health problems, problem frequency of BIP clients, developmental diagnostic formulation, and program components. Three case vignettes are included. (Contains 10 references.) (TD)

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Wilderness Adventure Therapy in Adolescent Psychiatry

By Simon Crisp & Matthew O'Donnell

This paper provides an overview and illustration of developmental/psychodynamic approaches in wilderness-adventure therapy in the treatment of serious emotional, behavioural and psychiatric problems of adolescents. The Brief Intervention Program is used to illustrate a framework of multi-modal wilderness-adventure therapy as part of an overall mental health treatment approach. Case study vignettes are presented to illustrate individualised eclectic treatment interventions based on a developmental understanding.

Mental Health Problems of Adolescence

Developmental tasks.

Adolescence is a phase of development typically characterised by rapid physical, cognitive, social and psychosexual development. Table 1 summarises the key tasks of this phase. Periods of turmoil are experienced as the adolescent makes the transition from economic and emotional dependence on the primary family unit to broader social networks. Typically this is achieved via a shift of identification, affiliation and attachments from parents and siblings to the peer group (Lidz, 1983). Further, psychological maturation demands the capacity to develop intimate relationships outside the family. An overriding issue for adolescents is making this transition while both maintaining stability of identity but also extending their self-concept as they build foundations for future adult life.

Etiology.

Partly because of the critical importance to adult maturity of these developmental tasks, adolescence is a time of peak incidence of mental health problems. Indeed, many psychiatric disorders of adulthood have their onset during this time. Predisposing influences include things like stressful life events, the death of a family member, family crises or dysfunction, and traumatic events such as physical or sexual abuse. These incidents increase vulnerability to mental health problems because of the interruption to normal development they may cause. Frequently this can result in regression to earlier

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Table 1.
Key Psycho-Social Developmental Tasks of Adolescence

Key psycho-social developmental task of adolescence
separation & detachment from parents and family
increased identification and attachment with peers
individuation through the development of autonomy, identity and moral development
development of a capacity for intimacy and sexuality
educational & vocational choice and completion
life-style choice

developmental stages as a means of coping, or forward development may become arrested. Commonly, this manifests in adolescents being unable to learn peer or adult relationship skills that are prerequisites for success in many important spheres of adult life. Table 2 summaries key issues involved in the etiology of mental health problems of adolescents.

Table 2.
Etiology of Mental Health Problems in Adolescence

Etiology of mental health problems in adolescence
rapid and tumultuous stage of transition which threatens to overwhelm the resources of the adolescent because of a *lack of adequate coping skills*
earlier developmental issues re-emerge eg. attachment issues, management and control of emotion, dependence and independence ambivalence, rejection and acceptance, etc.
trauma (such as abuse) or *significant life events* (such as loss or neglect) may interrupt or delay earlier development causing the adolescent to continue with age-inappropriate behaviour
stresses experienced at this stage of transition may cause the adolescent to *'regress' to earlier stages* in an attempt to cope

Where mental health problems in adolescents emerge, interventions should ultimately aim to assist the adolescent move towards normal development. In order to do this it is necessary to understand the nature of the problem as it relates to the adolescent's developmental status and history of life events. Further, it is important to understand the context of the problem such as the family, peer and educational situation and any other relevant issues including protective and housing needs, and substance use and criminal behaviour. Once assessment of these factors has been made then informed recommendations can be offered. A treatment plan can then be developed; negotiated with all involved, monitored and finally evaluated to determine if treatment goals have been met (Davis-Berman & Berman, 1994).

The Brief Intervention Program (BIP)

The Brief Intervention Program (BIP) is a unique adolescent mental health day program established in 1992 to provide integrated, community focussed intervention and prevention. This is achieved by meeting the mental health needs of adolescents with severe emotional, behavioural, social and psychiatric disorders in the community without the disruption of in-patient hospital admission. The Victorian State Government Department of Human Services provides this service free to any adolescent and their family residing in the northeast Melbourne metropolitan area.

Providing a community focussed service, the Brief Intervention Program (BIP) has extended adolescent mental health services into the community through non-invasive engagement of disaffected adolescents with severe mental health problems who represent a high risk group for the development of further psychiatric disorder and/or suicide. It has been awarded the Australian Hospitals Association "Community Outreach Award" in the treatment of adolescent mental health problems. BIP and has been highlighted as a model of best practice in the prevention of suicide in high risk adolescents by the recent Victorian State Government's Suicide Prevention Task Force (Suicide Prevention: Victorian Task Force Report, 1997)

Client characteristics.

Adolescents aged 13 to 18 and their families are particularly targeted where they:

- are currently experiencing, or most at risk of serious psychiatric disturbance,
- are victims of physical, sexual or emotional abuse,
- are adolescents, who in addition to the above are clients of welfare and juvenile justice systems,
- are homeless,
- have parents who suffer from mental illness or dependence on drugs or alcohol,
- have educational or vocational difficulties.

Table 3 is based on referrers' data, clients serviced by the Brief Intervention Program present at the beginning of the program and shows that *on average*, every adolescent has *six* of these significant difficulties. These difficulties are most commonly in the areas of peer relationship problems, school refusal, family issues, school behavioural problems, and low self-esteem. Experience of abuse (emotional, sexual and physical combined) effect over half the client group at 53%. Depression, suicidal ideation, aggressive behaviour, and adult relationship problems effect over one-third of the client group. This represents a high level of multiple and interactive presenting issues and needs and places these clients at high risk of suicide.

Table 3.
Frequency of presenting problems amongst BIP clients (n=101)

PROBLEM	%	PROBLEM	%
Peer Relations	65	Victim of Bullying	26
Family Issues	59	Substance Abuse	19
Low Self-esteem	57	Physical Abuse	15
School Behaviour	52	Chronic Life Instability	13
School Refusal	48	Self Harming	13
Learning Difficult	42	Sexual Abuse	12
Depression	41	Housing Prob.s	12
Adult Relational Problems	38	Family Mental Illness	11
Suicidal Ideation	36	Sexuality Prob.s	11
Aggressive Behaviour	35	Intellectual Disability	7
Anxiety	32	Eating Disorder	5
Emotional Abuse	26	Other	6

Pre-referral assessment process.

The Brief Intervention Program is an intensive therapeutic option for more seriously disturbed adolescents referred to the Child & Adolescent Mental Health Service (CAMHS) at the Austin & Repatriation Medical Centre. Referral is made by a clinician following the completion of an adolescent "Developmental Psychiatric Assessment". As mentioned, this forms the basis of treatment planning prior to, during and at discharge from the program. Typically, the following information is gained from four to six 60-90 minute interviews.

The "family interview" (1-2 sessions with whoever lives in the household) assesses the dynamics and relationships within the family including the skills and unity of the parents. This includes: 1) the family structure (including extended family), alliances, boundaries, cohesion, communication styles; 2) the family context such as family history and significant life events or stressors, trans-generational issues, developmental stage of the family and so on. The "identified client's" function and role within the family system is understood by seeking the family members' perception of the *identified 'problem'*

The "interview with the adolescent" involves understanding their 'world view' and their view of the identified problem (initial reason for referral). Information is sought about their life events, interests, hobbies, peer relationships, attitude to school, family and home life, future expectations and so on. An assessment of the mental functioning of the adolescent is undertaken to ascertain the quality of emotional states, dominant thoughts, concept of self, cognitive functioning as well as the presence of psychiatric disturbance such as mood disorders, anxiety, psychotic symptoms, and so on. Importantly, this information is put in context of the adolescent's personal history and description of the

problem as they see it. Gaining an understanding of the quality of, and capacity for relationships is sought from the adolescent's response to the clinician.

Two "interviews with the parents" seek to gather information about all aspects of the adolescent's development from pregnancy onward. Information is gained about the medical, psychological, educational and social factors that have contributed to the adolescent's physical, personality and social development. Furthermore, the marital/parental relationship is assessed for its impact on the development of the adolescent and the capacity of the parents to adapt to the adolescent's current needs. A history of the parents' family of origin, including own experience of childhood and being parented, history and status of marital relationship helps to understand how these factors may influence the parents style of parenting and their response to the current difficulties their child faces.

Interviews may also be held with teachers, youth workers and any other relevant significant others to gain information that may be pertinent to gain a full understanding of the presenting problem. Many adolescents may have little relationship with their biological family, so interviews are held with foster family or other significant others as appropriate.

Developmental diagnostic formulation.

From the above interview information a 'diagnostic formulation' is made which seeks to answer the question: "why has *this adolescent* (and family), presented with *this problem*, at *this time*?" This is achieved by relating factors, which have contributed to the problem in the biological, psychological and social realms within a framework of ever-changing development. Table 4 shows the matrix of factors, which contribute, to a developmental diagnostic formulation.

Table 4.
Developmental Diagnostic Formulation

	Biological	Psychological	Social
Predisposing Factors	eg. birth complications	eg. low IQ, emotional neglect	eg. marital problems, parental absence
Precipitating Factors	eg. onset of puberty	eg. traumatic event	eg. move to high school
Maintaining Factors	eg. poor gross-motor co-ordination	eg. depression & hopelessness, anxiety	eg. family economic hardship
Protective Factors	eg. good health	eg. insight into self, sense of humour	eg. support from extended family

In a final session with the adolescent and family, this formulation is fed-back with any appropriate treatment recommendations. This is done in a way that clarifies issues and presents a rationale for the treatment recommendations. Recommendations may include

referral to BIP on its own or in conjunction with outpatient therapy such as individual, parent and/or family therapy.

Overview of BIP structure and time-frame.

The program comprises a closed group of 6-8 adolescents (13-18 years) over 10 weeks duration in parallel with school terms. Follow-up support is offered in following term at a frequency and duration that is appropriate for the need of the adolescent. The program is structured in three distinct phases: 1. engagement & orientation (week 1); 2. treatment (weeks 2-9); and 3. integration (week 10) & follow-up.

Key features of the program include:

- collaborative negotiation with adolescent & family of therapeutic objectives
- comprehensive planning and support for community integration from the outset of the program
- integrated weekly parent group therapy
- close liaison with all professionals and community services involved outside the department
- ready referral within the department to other therapy or services eg. long-term individual psychotherapy &/or family therapy
- multi-modal therapies with a high degree of integration of therapeutic components
- program dedicated multi-disciplinary team

Program components.

Program components are selected from the list in Table 5. A time-table of group and individual therapy is developed for each group based on the developmental level of the group (younger or older adolescents) and the pre-dominant issues that are most common to the majority of the group members.

Here wilderness-adventure therapy is integrated with other group and individual therapies through individual objective setting for the wilderness-adventure therapy component. Further, issues that arise in wilderness-adventure therapy are carried over into other groups as appropriate (such as psychotherapy group or cognitive-behaviour therapy group) and vis-versa. A major emphasis is given to the rehearsal of skills and roles learned from conventional therapy during appropriate times in wilderness-adventure therapy to assist in the transfer and generalizability of those skills into all areas of the adolescents' lives. Integration of behaviour change, insights and group roles from wilderness-adventure therapy are reinforced and generalised into other BIP components through processing exercises in other groups such as drama or music therapy.

Changes are supported in the adolescent's home environment through individual therapy, which may set homework tasks, use role-play and so on. These changes are monitored over time and during follow-up post-program.

Table 5.
Program Components

Type	Typical Frequency
Individual Therapy	(1 hour) twice per week
Group Psychotherapy	(1 hour) weekly
Group Cognitive-Behavioral Therapy	(2 hours)twice per week
Wilderness-Adventure Therapy	1 day per week & two 4-5 day expeditions
Work Experience	1 day per week
Sex-Education, Relationships, Personal Safety Group	(1 hour) weekly
Single-Sex Gender Issues Group	(45 min.s) weekly
Self-Defence Training	3 sessions per program
Drama Therapy	($1\frac{1}{2}$ hours) weekly
Group Music Therapy	(2hours) weekly
Living Skills Group	(2hours) weekly
Physical Education	(2hours) weekly
Recreation & Milieu Building Group	(30 min.s) weekly
Community Service	(2hours) weekly

Staffing.

BIP staff are qualified mental health professionals who have received specialist post-graduate training in developmental psychiatry as well as other specialist training in psychotherapy, family therapy, etc. Individual staff have additional training in group therapy in a number of different therapeutic modalities, for example group cognitive-behavioural therapy, group psychotherapy, music therapy, etc. Wilderness-adventure therapists (Clinical Psychologist and Occupational Therapist) are cross-trained in wilderness and adventure activities. The staff team is trained in many other non-speciality areas so content and methods are familiar to all staff to assist in integrating program components in a complimentary way.

Team composition is as follows: full-time Senior Clinical Psychologist (Director/Team Leader), full-time Occupational Therapist (Program Manager), half-time Clinical Psychologist and Social Worker, and two full-time Special Education Teachers. A Clinical Psychology Registrar (trainee psychologist) and a Wilderness-adventure Therapy Trainee both compliment the team on six-month placements.

Monitoring & evaluative research.

A detailed evaluation report of over 100 BIP clients is available from the authors (Kingston, Poot & Thomas, 1997). A summary of key features follows:

At Referral: An analysis of referral information for patient characteristics; psychiatric management needs and issues. Immediate Post-program Outcomes: Psychiatric symptomatology (Youth Self Report - YSR), coping behaviour (Adolescent Coping Scale - ACS), self-esteem (Coopersmith Self Esteem Inventory), life functioning (Life

Effectiveness Questionnaire - LEQ), etc. show a significant reduction in general psychopathology and an increase in self-esteem amongst other changes. Education / training placement outcomes, social adjustment, school adjustment, (teacher report) Housing, welfare, protective and family issues (case manager feedback)

Follow-up Outcomes: Immediate placement outcomes improved from 58% of the client group pre-program to 90% post-program. At 6-month follow-up placement rate was 72%. School refusal dropped from 34% of client group pre-program to 6% post-program and fell to 4% at 6-month follow-up. Behaviour status showed 31% of the client group were reported to have major difficulties pre-program, which reduced to 5% post-program and increased slightly to 9% at 6-month follow-up.

A Developmentally Based Framework of Wilderness-adventure Therapy

Given the complexity of client need, a highly individualised and eclectic approach based on a developmental understanding is most often used. A model of 'experiential reconstruction of developmental foundations' (Crisp, 1996) is used as the predominant approach along with other models such as cognitive-behavioural therapy, systemic, and strategic approaches. Here, regardless of the interventions and approaches used, they are based on, and compatible with a comprehensive developmental understanding and framework. The overriding aim is to address underlying causative factors (such as skill deficits or maladaptive inter-personal behavioural patterns) within the therapeutic constraints of the program.

Therapeutic premises of a developmental perspective.

Mental health problems result from gaps or delay (often after trauma) at one or more stages in an individual's development which significantly impede effective adjustment in that, and related areas. This occurs at the time as well as in subsequent developmental stages.

Developmental gaps or delay mean that the individual may be poorly prepared to meet his/her needs or complete future developmental tasks when older Lidz (1983). That is, individuals will show poor coping or adaptation, poor relationship skills, poor self-concept and self-worth, etc.

In a challenging, novel and projective situation (ie. wilderness-adventure context), individuals will relate to others in a more-or-less adaptive way to have their needs met (see Kimball 1993). This will highlight the adequacy of coping skills and highlight any developmental delays or gaps.

Some comments on therapeutic process.

What is unique to wilderness-adventure therapy is its experiential nature and its environmental setting. Therapy occurs typically through a process of forced adaptation on the part of the individual to the social-environmental situation that they are in. Given the holistic structure of many activities (which emphasise living skills, inter-personal skills, practical problem solving, etc.) there occurs a natural 'reconstruction' of the individual's developmental foundations as the individual corrects fundamental assumptions about him/herself and others (Crisp, 1996). Put another way, delayed, incomplete or unmastered developmental tasks can be learnt and/or rectified by tangible corrective experiences.

As most BIP clients present with relationship and related problems, re-experiencing corrective relationships with symbolic significant others such as mother/father figures, sibling figures, and so on becomes central to any therapeutic change. This means that the wilderness-adventure therapist holds a particularly important role in behaving towards each individual from an informed position so as not to repeat destructive past relationships which would only serve to reinforce the individual's view of others and themselves.

Psychoanalytic concepts of "transference" and "counter-transference" as well as more contemporary ideas of psychological defence mechanisms are particularly useful here. See Tippet (1993) and Salzberger-Wittenberg (1982) for a more detailed discussion.

A pivotal and unique characteristic of wilderness-adventure therapy is that when revisiting incomplete developmental tasks from an earlier stage, the application of higher level skills may be brought to old problems with newfound success. This is most clearly seen in adolescents who have rapidly developing cognitive and intellectual abilities. For example, a grossly deprived child some years later can provide shelter and nutrition for him/herself, or ask for and receive assistance as an adolescent and thereby counter formative experiences of neglect. Many aspects of extended wilderness expeditions have strong correlates with family life which gives a powerful opportunity for a corrective recapitulation of family relationships (Yalom, 1985).

Presentation of This Approach

Safeguarding the wilderness-adventure experience.

As discussed above, the wilderness-adventure therapist's knowledge of participant's developmental status from a comprehensive developmental assessment is both desirable to maximise his/her therapeutic impact and is important to design, construct and guide the wilderness-adventure experience toward the most appropriate therapeutic outcome. Another (albeit negative) way of thinking about this is that it is equally essential to be fully informed so as to know how *not* to traumatise your client, or further compound their problem.

While to most clients who have had well enough developmental progress, the wilderness environment is a wonderful or at worst a benign place. On the other hand, for those adolescents who are psychologically vulnerable, the outdoors can be a frightening place, and adventure based challenges may be a re-living of past traumas and clearly counter-therapeutic (Mitten, 1994). For example, strong encouragement to undertake a fearful challenge may be experienced as a repetition of an earlier abuse experience (ie. coercion or control). Similarly, symbolically or actually abandoning someone with poor attachment history can be experienced as a repetition of early trauma.

Eclectic wilderness-adventure therapy interventions based on a developmental framework.

Depending on individual client need, different and complimentary therapeutic approaches may be employed at different times within a wilderness-adventure therapy intervention. The four key paradigms used include 1) cognitive-behavioural therapy; 2) psychodynamic interventions; 3) systemic interventions; and 4) occupational therapy.

Cognitive-behavioural therapy.

Cognitive-behavioural therapy is based on the notion of reciprocal causal interaction of a) cognition, b) emotion and c) behaviour. Frequently, the aim of therapy for adolescents is to broaden the clients' range of responses to problematic situations. This often involves skill development in the following areas:

- anger management
- management of affect (emotions)
- communication skills
- conflict resolution
- problem solving skills
- assertiveness skills

An example of how this is applied might be an anxiety management strategy used during caving such as: a) the use of positive self-talk; b) challenging irrational beliefs about the situation; c) communication of need; d) asking for help from others; or e) using cognitive distraction techniques to minimise anxiety.

Psychodynamic interventions.

Typically involve the reworking past relationships with significant others such as parents and/or siblings. As stated above, a primary underlying assumption is that the client behaves according to unconscious needs and their expectations of the therapists and other clients ('transference'). This behaviour, and knowledge of the client's history informs therapists' responses to client behaviour ('counter-transference'). While theoretically complex, what is central to this approach is that the therapist's response provides a corrective experience, which helps the client resolve residual inner conflicts stemming from the experience of previous relationships. Additionally, the clients' unconscious perceptions, motivations, and drives may be understood and insight gained through the therapist's empathic interpretation of the client's inner experience. This can assist the client to form an understanding of the mechanisms and function of psychological defences, which may have been created at earlier stages of development as a means of coping.

Examples of this include: enacting a corrective relationship during an expedition, containing & not rejecting a provocative client with a history of neglect, providing assistance and support to a client who is excessively self-reliant, and providing consistent confrontation to a 'manipulative' client with a history of triangulation in the parental relationship.

Systemic interventions.

Systemic approaches may occur at many levels. At one level this includes case management of family and broader systems. At another level, the program milieu can be seen as a 'system', that is the interaction between therapeutic team and client group (eg. 'parallel process'). At yet another level, the group is conceptualised as a 'system', that is patterns of relationships and behaviour between clients. Finally, at the individual level,

interventions may seek to assist the individual to develop more adaptive functions or roles within the group system.

The following are examples of systemic interventions during white-water rafting:

- directing group roles and the group composition of the raft
- after team-work failure in one rapid, prescribing different behavioural tasks or roles in the raft to assist the clients to successfully negotiate the next rapid
- removing a competent paddler from the group to increase commitment and communication between remaining group members
- separate-sex raft groups to enhance gender identification and equality

Occupational therapy.

Involves the use of purposeful activity to enhance mental health and competence in a broad range of daily living skills (personal, inter-personal, educational, vocational, etc.). Occupational Therapy aims to gain age-appropriate competence in developmentally relevant skills in including the following areas:

- budgeting
- time-management / personal organisation
- recreation
- self-care / health maintenance / diet / fitness
- transportation
- accessing educational and/or vocational options

Examples of Occupational Therapy include using base camp tasks to develop living skills by:

- planning and preparing evening meal within a time-frame
- responsibility for self-care by appropriate clothing selection and proper use of sleeping and shelter equipment
- negotiation of the division of tasks within the group

Case Vignettes in Developmentally Based Wilderness-adventure Therapy

Case 1: Rockclimbing as a Projective Assessment, and the use of Transference with a 17 year old Girl with Depression and Social Phobia.

Client: Rachel is a 17-year-old female only child born of an unassertive, socially awkward mother and authoritarian and domineering father. Rachel attends a co-ed local high school and is in Year 11.

Presentation: Rachel had been in day-patient treatment for severe generalised anxiety, social phobia, and depression with suicidal ideation, low self-esteem and perfectionistic traits. She had be refusing to attend school for three months because of social phobia and failure to submit school work

Wilderness-adventure Therapy Intervention: 1-day rockclimbing & abseiling trip, grade 8-10 climbs (end of 2nd week of treatment) 9 metre (Grade 8 - novice standard) top-line belayed climb. The climb consisted of a 2-metre granite slab (moderately difficult), thin ledge, which extended sideways, then 7 metre of parallel cracks with some handholds.

Rachel was given standard climbing and belaying instructions and directed to set her own hight goal on the climb. She was unable to get a foothold on the first 2-metre slab with decreasing effectiveness, becoming increasingly frustrated and helplessness. She laughed to disguise her sense of failure and frustration. She sought permission from the therapist to discontinue in the face of hopelessness. A peer suggested she avoid difficult start. Rachel deferred to the therapist (therapist used his 'counter-transference' to inform his response). Therapist responded "Sometimes it's okay to re-evaluate the rules you operate by..." Rachel walked around the slab, along the ledge then successfully completed the climb to the very top.

Outcome: Individual de-briefs found that this style reflected Rachel's approach to many other situations. Rachel was encouraged to use this solution as a metaphor for approaching other life situations where she 'got stuck', felt hopeless and gave in

Case 2: Abseiling as re-working of family relationships for 15-year-old boy with depression and substance abuse.

Client: Mark is a15 year old adolescent with an older sister (19) and older stepbrother (23). Mark's father was authoritarian, obsessional and emotionally distant and his mother was over-protective. Parents were very distant from each other. Mark lives in bungalow in the back yard, staying out all night smoking cannabis with peers

Presentation: had previous day-patient treatment for depression, drug abuse, stealing from family, socially isolated, severe and frequent epilepsy since childhood, school refusal, low self-esteem. He refused to go to school because of low self-esteem, academic problems, and social isolation. Mark was silent and withdrawn in family therapy (was talked about but did not speak)

Wilderness-adventure Therapy Intervention: 1-day abseiling trip, 15-metre abseil from flat ledge to over-hang.

Mark was relatively competent with abseiling in previous shorter abseils. He used a 'blind-fold' used to increase challenge. He was instructed to abseil over edge as normal - therapist offered no other directions. He began slowly, cautious and shaky in moving towards edge, lost balance at times asked by therapist how it felt, if this reminded him of his path in life in recent months? Would it be easier if others were able to give him advice? What was stopping him from asking for help, advice or directions? He then began to ask therapists at top, and then at bottom for directions. He successfully negotiated abseil to bottom with greater certainty and volition. Mark thanked both therapists for helping him through, while still owning the success.

Outcome: De-brief found that he avoided asking for help from parents because he got conflicting advice, none of which helped him with his day-to-day issues. After treatment he moved out with father and rebuilt bicycles together, returning to school.

Case 3: Abseiling as an experience of re-working severe attachment & separation anxiety in a 15 year old boy with attachment disorder, generalised anxiety, phobia & psychosis

Client: Adam is a15 year old boy with two younger siblings from severely chaotic and enmeshed family with multi-generation mental illness. He was raised by chronic schizophrenic father & grandmother in the absence of mother for last 10 years, mother suffered post-natal and recurrent major depression. Adam had long history of disrupted attachment and maternal unavailability.

Presentation: Adam had previous day-patient treatment for extreme generalised anxiety, range of phobias (inc. public transport), psychosis (NOS), including delusions of stunted growth, poor peer relationships, and learning difficulties. He was jealous of

youngest brother, Adam had 'scapegoat' role in family. He was a victim of teasing and bullying, and extremely dependency on teachers at school.

Wilderness-adventure Therapy Intervention: Adam showed extreme separation anxiety in the previous overnight hike and camp. Abseil (4-5metre) with sloping ledge at beginning (2 metre) then vertical drop for last 3 metres.

Adam was highly anxious just watching others abseil, claiming "not going to do it..." He was encouraged to climb up behind dispatch area to watch ("bring gloves up with you...") and encouraged to clip on "just to see what it was like...." He was further encouraged to just try the first (gently sloping) face (2 metre). Adam insisted that the therapist follow him in close proximity down to edge. He got to edge of vertical drop and experienced a controlled panic and long hesitation/distress. He was encouraged to use anxiety management strategies (deep breathing, focussing, etc.). An interpretation was made about similar difficulty separating from father. He continued on his own with verbal support, past edge and away from therapist. He then appeared to experience high anxiety and then broke into laughter before reaching bottom

Outcome: Adam attributed his success as being contingent upon therapist's assistance. He was able to acknowledge self-sufficiency in spite of a new and fearful situation. Abseiling used as an analogy for further experiences demanding independence in on-going therapy.

Conclusion

It is the author's belief that a developmentally based treatment approach with adolescents is most appropriate and effective in addressing their core mental health issues. This is commonly achieved because traumatic, insufficient, or incomplete developmental experiences can be corrected to the point of allowing the adolescent to complete the psychological and social foundations necessary to master future developmental tasks. This in turn can provide protection against future mental health problems and reduce the severity and impact on life functioning of any current psychiatric and related problems.

In order to be most effective in this way, a comprehensive developmental understanding needs to be gained from a thorough bio-psycho-social assessment of the adolescent and their family context. When an understanding based on a formulation of predisposing, precipitating, maintaining and protective factors is used to guide therapeutic interventions a truly individualised approach can be taken. Here a range of interventions can be tailored to meet each client's specific needs. Most commonly used interventions include cognitive-behavioural, psychodynamic, systemic and occupational therapy. In the author's experience, these interventions have been found clinically to be most appropriate and relevant to the specific developmental needs of adolescents.

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